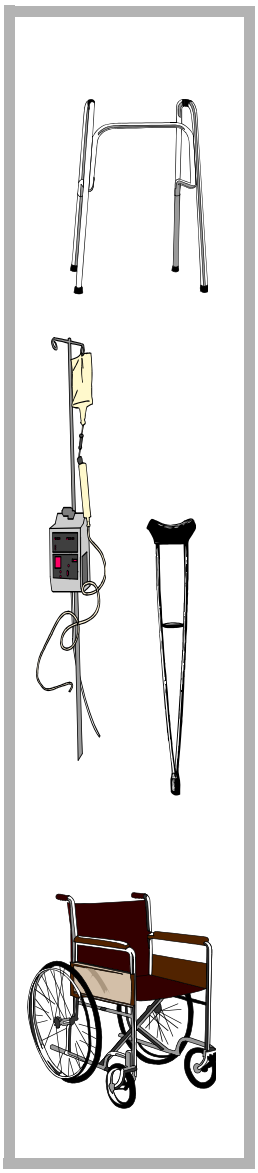

Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2005

This publication supersedes all previous Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) handbooks. Published by the Montana Department of Public Health & Human Services, January 2005.

Updated January 2005, April 2005.

My Medicaid Provider ID Number:

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Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals, fee schedules:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Technical Services Center

Providers who have questions or changes regarding electronic funds transfer should call the number below and ask for the Direct Deposit Manager.

(406) 444-9500

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-0357 Fax

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions or issues:

(406) 444-4068 Phone Program Officer
(406) 444-5296 Phone Claim Specialist
(406) 444-1861 Fax

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC)

For coding advice and other SADMERC information:

(877) 735-1326
Mon-Fri 9:00 a.m.- 4:00 p.m. Eastern Time

SADMERC
P.O. Box 100143
Columbia, SC 29202-3143

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

Quality Assurance Division

For prior authorization for certain services (see the *Prior Authorization and PASSPORT* chapter in this manual) contact:

For clients with last names beginning with **A - K**, call:

(406) 444-3993 In/out-of-state

For clients with last names beginning with **L**, call:

(406) 444-6977 In/out-of-state

For clients with last names beginning with **M - Z**, call:

(406) 444-0190 In/out-of-state

Information may be faxed to:

(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review Section
Prior Authorization
P.O. Box 202953
Helena, MT 59620-2953

Key Websites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, Mental Health Services Plan information, program information, office locations, divisions, resources, legal information, and links to other state and federal websites.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
Client Information Website www.dphhs.mt.gov/hpsd/medicaid/medrecip/medrecip.htm	• Medicaid program information • Client newsletters • Who to call if you have questions • Client Notices & Information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides
Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) http://www.palmettogba.com/index.html	SADMERC information is available under *Other Partners.* This website assists manufacturers and suppliers with DMEPOS billing and coding information.
CIGNA Medicare DMERC Region D http://www.cignamedicare.com/dmerc/index.html	Equipment Regional Carriers (DMERCs) website. DMERC processes Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for Medicare.

Key Websites (continued)

Web Address	Information Available
ARM Rules http://www.dphhs.mt.gov/legal_section/administrative_rules_montana/arm_title_37/arm_title_37.htm	Administrative Rules of Montana
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides and other tools • EDI education
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for providers of Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS). Other essential information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both the general manual and the specific manual for his or her provider type.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rule references are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). The following rules and regulations are specific to the DMEPOS program. Additional Medicaid rule references are available in the *General Information For Providers* Manual.

- Administrative Rules of Montana (ARM)
    - ARM 37.86.1801 - 37.86.1807 Prosthetic Devices, Durable Medical Equipment and Medical Supplies

Providers are responsible for knowing and following current laws and regulations.

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

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Covered Services

General Coverage Principles

This chapter provides covered services information that applies specifically to services and supplies provided by Durable Medical Equipment, Prosthetic, Orthotic and Medical Supply (DMEPOS) providers. Like all health care services received by Medicaid clients, services rendered by these providers must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

Montana Medicaid follows Medicare's coverage requirements for most items. A Medicare manual is available from the DMERC website. The Provider Information website contains a link to the DMERC site (see *Key Contacts*). Montana Medicaid considers Medicare, Region D, DMERC medical review policies as the minimum DMEPOS industry standard. This manual covers criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Montana Medicaid coverage determinations are a combination of Medicare, Region D DMERC policies, Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions, and Department designated medical review decisions. DMEPOS providers are required to follow specific Montana Medicaid policy or applicable Medicare policy when Montana Medicaid policy does not exist. When Medicare makes a determination of medical necessity, that determination is applicable to the Medicaid program.

Services for children (ARM 37.86.2201 – 2221)

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is a comprehensive approach to health care for Medicaid clients under age 21. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid eligible children may receive any medically necessary covered service, including DMEPOS items/services described in this manual. All applicable prior authorization requirements apply.

Provision of services (ARM 37.86.1802)

Federal regulations require that items/services covered by the Department are reasonable and necessary in amount, duration and scope to achieve their purpose. DMEPOS items/supplies must be medically necessary, prescribed in writing and delivered in the most appropriate and cost effective manner, and may not be excluded by any other state or federal rules or regulations.

Supplier documentation (ARM 37.86.1802)

Prescriptions for DMEPOS items must include the diagnosis, medical necessity, and projected length of need for the item.

All covered DMEPOS items for clients with Medicaid as the primary payer, must be prescribed in writing prior to delivery by a physician or other licensed practitioner of the healing arts within the scope of the provider's practice as defined by state law. The prescription must indicate the diagnosis, the medical necessity, and projected length of need for the covered item. Prescriptions for medical supplies used on a continuous basis shall be renewed by a physician at least every 12 months and must specify the monthly quantity. Prescriptions for oxygen must also include the liter flow per minute, hours of use per day and the client's P02 or oxygen saturation blood test results.

Even though a prescription is required, coverage decisions are not based solely on the prescription. Coverage decisions are based on objective, supporting information about the client's condition in relation to the item/service prescribed. Supporting documentation may include, but is not limited to (if applicable) a Certificate of Medical Necessity (CMN) and/or a physician's, therapist's or specialist's written opinion/attestation for an item/service based on unique individual need. The DMEPOS fee schedule indicates the items that require a CMN.

The effective date of an order/script is the date in which it was signed.

The client's medical record must contain sufficient documentation of the client's medical condition to substantiate the necessity for the prescribed item/service. The client's medical record is not limited to the physician's office records. It may include hospital, nursing home, or home health agency records and records from other professionals including, but not limited to, nurses, physical and occupational therapists, prosthetists, and orthotists. It is recommended that suppliers obtain (for their files) sufficient medical records to determine whether the client meets Medicaid coverage and payment rules for the particular item.

Proof of delivery is required in order to verify that the client received the DMEPOS item. Proof of delivery documentation must be made available to the Department upon request. Medicaid does not pay for delivery, mailing or shipping fees or other costs of transporting the item to the client's residence.

Providers must retain the original prescription, supporting medical need documentation and proof of delivery. For additional documentation requirements, see the *General Information for Providers* manual, *Provider Requirements* chapter.

Certificate of medical necessity

For a number of DMEPOS items, a certificate of medical necessity (CMN) is required to provide supporting documentation for the client's medical indication(s). The "CMN" column of the Montana Medicaid fee schedule indicates if a CMN is required. Montana Medicaid adopts the CMNs used by Medicare Durable Medical Equipment Regional Carriers (DMERCs), approved by the

Office of Management and Budget (OMB), and required by the Centers for Medicare & Medicaid Services (CMS). These forms are available in *Appendix A: Forms*, on the Provider Information website (see *Key Contacts*) and on the following websites:

http://www.cms.hhs.gov/providers/mr/cmn.asp

http://www.cignamedicare.com/dmerc/dmsm/C04/sm04_INDEX.html

The following is a list of items that require a CMN and the corresponding form. This reference list will be updated as changes are made. If any discrepancies exist between these referenced forms and what is published by CMS and Cigna Medicare, then the CMS and Cigna Medicare policy shall take precedence.

CMN Forms

Item	Form	Date
Enteral Nutrition	CMS-853	04/96
External Infusion Pump	CMS-851	04/96
Hospital Beds	CMS-841	04/96
Lymphedema Pumps (Pneumatic Compression Devices)	CMS-846	05/97
Manual Wheelchairs	CMS-844	05/97
Motorized Wheelchairs	CMS-843	05/97
Osteogenesis Stimulators	CMS-847	05/97
Oxygen	CMS-484	11/99
Parenteral Nutrition	CMS-852	04/96
Power Operated Vehicles (POV)	CMS-850	04/96
Seat Lift Mechanisms	CMS-849	04/96
Section C Continuation Form	CMS-854	05/97
Support Surfaces	CMS-842	04/96
Transcutaneous Electrical Nerve Stimulators (TENS)	CMS-848	04/96

Rental/purchase (ARM 37.86.1801 - 1806)

The rental period for items identified by Medicare as capped, routine or inexpensive are limited to 12 months of rental reimbursement. After 12 months of continuous rental, the item is considered owned by the client and the provider must transfer ownership to the client. Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental are limited to 120% of the purchase price for that item. If purchasing the rental item is cost effective, the Department may cover the purchase of the item.

A statement of medical necessity for rental of DME equipment must indicate the length of time the equipment is needed, and all prescriptions must be signed and dated.

Servicing. During the 12-month rental period, Medicaid rental payment includes all supplies, maintenance, repair, components, adjustments and services related to the item during the rental month. Separately billable supply items identified and allowed by Medicare are also separately billable to Medicaid under the same limitations. No additional amounts related to the item may be billed or reimbursed for the item during the 12-month period. During the rental period, the supplier providing the rental equipment is responsible for all maintenance and service. After the 12-month rental period when ownership of the item is transferred to the client, the provider may bill Medicaid for the supplies, maintenance, repair components, adjustment and services related to the items. Medicaid does not cover repair charges during the manufacturer's warranty period.

Items classified by Medicare as needing frequent and substantial servicing are covered on a monthly rental basis only. The 12-month rental limit does not apply and rental payment may continue as long as the item is medically necessary.

Interruptions in rental period. Interruptions in the rental period of less than 60 days will not result in the start of a new 12-month period or new 120% of purchase price limit. Periods in which service is interrupted do not count toward the 12-month rental limit.

Change in supplier. A change in supplier during the 12-month rental period will not result in the start of a new 12-month period or new 120% of purchase price limit. Providers are responsible to investigate whether another supplier has been providing the item to the client; Medicaid does not notify suppliers of this information. The provider may rely upon a separate written client statement that another supplier has not been providing the item, unless the provider has knowledge of other facts or information indicating that another supplier

has been providing the item. The supplier providing the item in the twelfth month of the rental period is responsible for transferring ownership to the client.

Change in equipment. If rental equipment is changed to different but similar equipment, the change will result in the start of a new 12-month period or new 120% of purchase price limit only when all of the following are met:

- The change in equipment is medically necessary as a result of a substantial change in the client's medical condition.
- A new certification of medical necessity for the new equipment is completed and signed by a physician.

Non-covered services (ARM 37.86.1802)

The following are items and/or categories of items that are not covered through the DMEPOS program. All coverage decisions are based on federal and state mandates for program funding by the U.S. Department of Health and Human Services, including the Medicare Program or the Department's designated review organization.

- Adaptive items for daily living
- Environmental control items
- Building modifications
- Automobile modifications
- Convenience/comfort items
- Disposable incontinence wipes
- Sexual aids or devices
- Personal care items
- Personal computers
- Alarms/alert items
- Institutional items
- Exercise/therapeutic items
- Educational items
- Items/services provided to a client in a nursing facility setting (see the *Nursing Facility Services* manual for details)

Verifying coverage

The easiest way to verify coverage for a specific service is to check the Department's fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must also meet the coverage criteria listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in this chapter. Use the current fee schedule in conjunction

Use the current fee schedule for your provider type to verify coverage for specific services.

with the more detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. Take care to use the fee schedule and coding books that pertain to the date of service.

Current fee schedules are available on the *Provider Information* website, disk, or hardcopy. For disk or hard copy, contact Provider Relations (see *Key Contacts*).

Coverage of Specific Services

No more than one month's medical supplies may be provided to a client at one time.

The following are specific criteria for certain items/services which are either in addition to Medicare requirements or are services Medicare does not cover.

Apnea Monitors

The rental of an apnea monitor will be covered initially for a six-month period from the date of the physician's order. Apnea monitors are covered under at least one of the following conditions:

- A sibling has died from SIDS
- Infant has symptomatic apnea
- Observation of apparent life-threatening events (ALTE)
- Infant is on oxygen
- Symptomatic apnea due to neurological impairment

For coverage after the initial six-month period, additional months coverage must be prior authorized by the Department and the following conditions must exist and be documented by the physician:

- Infant continues to have significant alarms (log must be kept on file)
- Unresolved symptomatic apnea

Diapers, under pads, liners/shields

Diapers, under pads, liners and shields are covered for individuals who have a medical need for the items based on their diagnosis. These items are not covered for clients under three years of age or clients in long term care (nursing facility) settings.

Disposable diapers are limited to 180 diapers per month. Disposable under pads, liners/shields are limited to 240 per month. Reusable diapers, under pads, liners/shields are limited to 36 units each per year.

Electric breast pump

The use of an electric breast pump is considered medically appropriate if at least one of the following criteria is met:

- Client has a pre-term infant of 37 weeks or less gestation

- Client's infant has feeding difficulties due to neurological or physical conditions which impairs adequate suckling
- Illness of mother and/or infant that results in their separation
- Mother is on medication that compromises milk supply

Electric breast pump rental is limited for two months unless additional months are prior authorized by the Department. Medicaid covers all supplies, maintenance, repair, components, adjustments and services related to the pump. Payment may not be provided through the infant's eligibility for Medicaid.

Oral nutrition

Medicaid may cover oral nutritional products for clients under the age of 21 who have had an EPSDT screen resulting in a diagnosed medical condition that impairs absorption of a specific nutrient(s). The client must also have a measurable nutrition plan developed by a nutritionist and the client's primary care provider (PCP).

Pulse oximetry meter

A pulse oximetry meter measures oxygen saturation levels using a noninvasive probe. Pulse oximetry meters provide an estimate of arterial oxyhemoglobin saturation (SaO2), using selected wavelengths of light, to determine the saturation of oxyhemoglobin (SpO2).

A pulse oximetry meter is covered for ventilator dependent patients. Continuous read oximetry meters and any meter used for diagnostic purposes are not covered.

A pulse oximetry meter is covered for adult patients when all of the following criteria are met:

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- A medical need exists in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not immediately treated.
- A trained caregiver is available to respond to changes in oxygen saturation.

A pulse oximetry meter is covered for pediatric patients when all of the following criteria are met:

- The client has a chronic, progressive respiratory or cardiovascular condition that requires continuous or frequent oxygen therapy.
- Oxygen need varies from day to day or per activity (e.g., feeding, sleeping, movement), and a medical need exists to maintain oxygen saturation

within a very narrow range in which unpredictable, sub-therapeutic fluctuations of oxygen saturation levels occur that cannot be clinically determined and have an adverse effect if not treated.

- A trained caregiver is available to respond to changes in oxygen saturation.

Standing frame

A standing frame is used to develop weight bearing through the legs for those who cannot stand independently. Standers may be fixed or adjustable in their design. Accessories must contribute significantly to the therapeutic function of the device. Designs and accessories primarily for a caregiver's convenience are not considered medically necessary. For the coverage of a standing frame, the following conditions must be met:

- Client can demonstrate tolerance for standing and partial weight bearing
- Client and/or caregivers demonstrate the capability and motivation to be compliant in the use of the standing frame
- Client is unable to stand without the aid of adaptive equipment
- Clients must be involved in a therapy program established by a physical or occupational therapist. The program must include measurable documented objectives related to the client and equipment that includes a written carry over plan to be utilized by the client and/or caregiver. The equipment must match the user's needs and ability level.

Wheelchairs

In addition to the Medicare, Region D, DMERC Medical Review Policies for wheelchairs, the following also applies. In order to meet the needs of a particular individual, various wheelchair options or accessories are typically selected. The addition of options or accessories does not deem the wheelchair one that is custom.

Wheelchairs in nursing facilities

Nursing facilities are expected to make available wheelchairs with typical options or accessories in a range of sizes to meet the needs of its residents. If a typical option or accessory is not available for a currently owned nursing facility wheelchair, an accommodating wheelchair is expected to be made available by the nursing facility. Only wheelchairs (including power chairs) that cannot be reasonably used by another nursing home resident will be considered for purchase. Wheelchairs must be used primarily for mobility. Roll-about chairs which cannot be self propelled are specifically designed to meet the needs of ill, injured, or otherwise impaired individuals and are considered similar to wheelchairs. Roll-about chairs may be called by other names such as *transport* or *mobile geriatric* chairs (Geri-Chairs). Roll-about chairs are not wheel-

chairs; however, many of the same options and accessories can be found for use on them. Like standard wheelchairs, roll-about chairs are expected to be available to residents by the nursing facility.

Other Programs

This is how the information in this manual applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

The information in this manual does not apply to the Mental Health Services Plan (MHSP). For more information on the MHSP program, see the *Mental Health Manual* available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this manual does not apply to CHIP clients. For a CHIP medical manual, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional information regarding CHIP is available on the CHIP website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

Prior Authorization and PASSPORT

What Are PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120))

PASSPORT To Health, prior authorization (PA) and the Team Care Program are examples of the Department's efforts to ensure the appropriate use of Medicaid services. In most cases, providers need approval before services are provided to a particular client. **PASSPORT approval is not required for DMEPOS services, and Team care does not apply**.

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim.

Medicaid does not pay for services when prior authorization requirements are not met.

Prior Authorization (ARM 37.85.410, 37.86.1806)

To ensure federal funding requirements are met, certain items/services are reviewed before delivery to a Medicaid client. These items/services are reviewed for appropriateness based on the client's medical need. In determining medical appropriateness of an item/service, the Department or designated review organization may consider the type or nature of the service, the provider of the service, the setting in which the service is provided and any additional requirements applicable to the specific service or category of service.

If an item/service is considered medically necessary, payment authorization is based on when the request was received for review from the provider, not the delivery of the item/service to the client.

Prior authorization is **not** required for dispensing units over the maximum allowable; however, documentation supporting medical necessity must be kept on file.

When requesting prior authorization, remember:

- Only Medicaid enrolled DMEPOS providers may request PA for items/services.
- In circumstances where another insurance carrier is primary and payment has been made, PA is not required.
- Documentation must support medical necessity.
- Documentation must coincide with other documentation provided by those involved with the client.
- Documentation must be complete, including appropriate signatures and dates.
- Client must be eligible for Medicaid.
- Use the correct CMN for the item/service (if required).
- Use current correct coding.
- Use the appropriate place of service – 12 for home or 32 for nursing facility (see *Appendix B: Place of Service Codes*).
- Do not submit a PA request solely for denial in order to receive payment from another source. Instead, provide the requesting payer with documentation supporting non-coverage of the item (provider manuals, notices, newsletters, or request documentation from Provider Relations).

Granting of prior authorization does not guarantee payment for the item/service.

To request prior authorization for an item/service:

- Submit a completed *DMEPOS Prior Authorization Request Form* (see *Appendix A: Forms*)
- Include appropriate supporting documentation with the request (see the following *PA Criteria* table).
- Fax or mail the request and supporting documentation to the Quality Assurance Division, Surveillance/Utilization Review Section (see the following *PA Criteria* table).
- Upon completion of the review, the client and the requesting provider are notified. The provider receives an authorization number that must be included on the claim. If the requesting provider does not receive the authorization number within 10 business days of being notified of the review approval, the requesting provider may call Provider Relations (see *Key Contacts*).

PA Criteria

Covered Service	PA Contact	Requirements

• **Item/Service over $1,000** (when the Department fee for any single line item is is greater than or equal to $1,000)
• **Item/Service shown on the Department fee schedule with a PA indicator**
• **Items/services** that are unique in their function/use in comparison to other items/services in the same category
	Surveillance/Utilization Review Section
	Prior Authorization
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	For clients with last names beginning with **A - K**, call:
	(406) 444-3993 In/out-of-state
	
	For clients with last names beginning with **L**, call:
	(406) 444-6977 In/out-of-state
	
	For clients with last names beginning with **M - Z**, call:
	(406) 444-0190 In/out-of-state
	
	Fax:
	(406) 444-0778
		Medical necessity documentation must include all of the following:
		• Completed DMEPOS Prior Authorization Request form
		• Supporting documentation, which must include at a minimum:
		  • Prescription
		  • Certificate of medical need (if required for the item)
		  • Narrative summary from the prescribing authority detailing the need for the item
		  • A manufacturers retail price sheet and product warranty information
		  • For clients being treated by a licensed therapist, a copy of the client's plan of care in relation to the item/service is required

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Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (TPL). See the *General Information For Providers* manual, *Client Eligibility and Responsibilities*. If Medicare or other carrier information is known, the Medicare ID number is provided or the carrier is shown on the eligibility information. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation Insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not considered a TPL.

Medicare Part B crossover claims

DMEPOS items and services are covered under Medicare Part B. The Department has an agreement with Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of professional claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When clients have both Medicare and Medicaid covered claims, and the provider has made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

In order to avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see *Billing Electronically with Paper Attachments* in the *Submitting a Claim* chapter in this manual.

All Part B Crossover claims submitted to Medicaid before the 45-day response time from Medicare will be returned to the provider.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Services (IHS) or Crime Victim's Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- When a client has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification to the Third Party Liability Unit (see *Key Contacts*).

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
    - The third party carrier has been billed, and 30 days or more have passed since the date of service.

- The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the Third Party Liability Unit (see *Key Contacts*).

Blanket denials

Providers who routinely bill for Medicaid covered services that other insurance companies do not cover, may request a blanket denial letter. Providers may complete a *Request for Blanket Denial Letter* (located in *Appendix A: Forms* and on the Provider Information website) and submit the form to the Third Party Liability Unit (see *Key Contacts*). The TPL Unit usually requests the provider send an explanation of benefits showing the services have been denied by the client's other insurance company. The provider is then notified that the services have been approved for a blanket denial.

Providers who bill electronically (ANSI ASC X12N 837 transactions) will receive a memo from the TPL Unit with a tracking number for use when billing Medicaid. This number must be included in the *paperwork attachment indicator* field when billing electronically for the specific services.

Providers who bill on paper will receive a memo from the TPL Unit. This Memo must be copied and submitted with each claim for the approved procedure codes.

The number can be used for two years, and then the provider must submit a new *Request for Blanket Denial Letter.* Any claims submitted with procedure codes not listed (or not approved) on the Memo must be submitted with a specific denial from the other insurance company or Medicaid will deny those services.

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Billing Procedures

Claim Forms

Services provided by the health care professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form (formerly known as the HCFA-1500). CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
    - the date of service
    - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
    - ***Medicare Crossover Claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
    - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12 month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

Usual and Customary Charge (ARM 37.85.406, 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For more information on reasonable charges, see the *How Payment is Calculated* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments either.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and he or she must pay for the services received.

Custom Agreement: This agreement lists the service the client is receiving and states that the service is not covered by Medicaid and that the client will pay for it.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for DMEPOS items/services is $5.00 per visit. The following clients are exempt from cost sharing:

- Clients under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients. A provider may sever the relationship with a client who has unpaid cost sharing obligation, as long as a consistent policy is followed with Medicaid and non-Medicaid clients. Once the relationship is severed, with prior notice to the client either verbally or in writing, the provider may refuse to serve the client.

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (Eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

For more information on retroactive eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page.

Coding tips

The following suggestions may help reduce coding errors and unnecessary claim denials:

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- If a provider is unable to determine the appropriate code for a covered item/service from such publications, contact the manufacturer or dis-

tributor of the item/service for coding guidance. Providers may also contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for coding advice (see *Key Contacts*).

- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use the correct "units" measurement on CMS-1500 claims. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Always check the long text of the code description. When billing for rentals, for example, 1 unit equals one month of rental.

Miscellaneous/not otherwise specified HCPCS codes

Most HCPCS Level II coding categories have miscellaneous/not otherwise specified codes (e.g., equipment, orthotics, prosthetics, supplies, etc.). Providers must determine if an alternative HCPCS Level II code better describes the item/service being reported. These codes should only be used if a more specific code is unavailable. Claims containing a miscellaneous/not otherwise specified HCPCS must have one of the following:

- A description of the item/service attached to the claim (see *Billing electronically with paper attachments* in the *Submitting a Claim* chapter of this manual)
- A description of the item included on the claim form directly to the right or below the code used.

Failure to include such descriptions will result in the claim being denied.

Claims containing miscellaneous/not otherwise specified HCPCS codes are subject to prepayment review. Review of these claims may result in processing and payment delays. Claim processing staff are dedicated to processing claims as quickly as possible to avoid lengthy delays in payment. Providers must provide clear and complete descriptions of the item/service on the claim line or on an attachment to assist in minimizing delays. For more information on claim status, see the *Remittance Advices and Adjustments* chapter in this manual.

Prepayment review is not a prior authorization process before delivery of the item and the payment of a claim does not mean that the item/service was reviewed for its necessity and/or appropriateness. Paid claims are subject to retrospective review auditing.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm

Using the Medicaid Fee Schedule

When billing Medicaid, it is important to use the Department's fee schedule for your provider type in conjunction with the detailed coding descriptions listed in the current CPT-4 and HCPCS Level II coding books. In addition to covered services and payment rates, fee schedules often contain helpful information such as appropriate modifiers. Department fee schedules are updated each January. Current fee schedules are available on the *Provider Information* website (see *Key Contacts*). For disk or hardcopy, contact Provider Relations (see *Key Contacts*).

Place of Service

Place of service must be entered correctly on each line (see *Appendix B: Place of Services Codes).* Medicaid typically reduces payment for services provided in hospitals and ambulatory surgical centers since these facilities typically bill Medicaid separately for facility charges.

Date of Service

The date of service for custom molded or fitted items is the date upon which the provider completes the mold or fitting and either orders the equipment from another party or makes an irrevocable commitment to the production of the item.

Rental

Payment includes the entire initial month of rental even if actual days of use are less than the full month. Payment for second or subsequent months is allowed only if the item is used at least 15 days in such months.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- The Medicaid claims processing system recognizes only two pricing modifiers and one informational modifier per claim line. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Use modifier -BO when nutrition is orally administered, not by a feeding tube.
- Claims where Medicaid is the primary payer are paid on a monthly basis. These claims are submitted using the -RR modifier with one unit of service. For example, a client rents a nebulizer. The first rental month is billed as one unit as shown:

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM DD YY	MM	DD	YY												
1 08 21 04	08	31	04			12	0	E0570 RR	1	25 00	1				

Another example is a client who uses oxygen. Regardless of how much oxygen is used during a month, it is billed as 1 unit as follows:

24. A						B	C	D	E	F	G	H	I	J	K
DATE(S) OF SERVICE From			To			Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER	DIAGNOSIS CODE	$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
MM DD YY	MM	DD	YY												
1 08 01 04	08	31	04			12	0	E1390 RR	1	250 00	1				

Submitting a Claim

See the *Submitting a Claim* chapter in this manual for instructions on completing claims forms, submitting paper and electronic claims, and inquiring about a claim.

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each paper claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be computer generated, typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require an electronic professional claim or a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • View the client's eligibility information at each visit. Medicaid eligibility may change monthly. • Verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
Duplicate claim	• Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form (see the *PASSPORT and Prior Authorization* chapter in this manual).
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) included (see *Billing Electronically with Paper Attachments* in the *Submitting a Claim* chapter in this manual.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.

Submitting a Claim

Electronic Claims

Professional claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an 837 transaction, but does not accept an 835 (electronic RA) transaction back from the Department. The software can be downloaded directly from the ACS EDI Gateway website. For more information on WINASAP 2003, visit the ACS EDI Gateway website, or call the number listed in the *Key Contacts* section of this manual.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway. For more information on using the ACS clearinghouse, contact ACS EDI Gateway (see *Key Contacts*).
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway.

Providers should be familiar with the *Implementation Guides* that describe federal rules and regulations and provide instructions on preparing electronic transactions. These guides are available from the Washington Publishing Company (see *Key Contacts*). *Companion Guides* are used in conjunction with *Implementation Guides* and provide Montana-specific information for sending and receiving electronic transactions. They are available on the ACS EDI Gateway website (see *Key Contacts*).

Billing electronically with paper attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the *Companion Guides* located on the ACS EDI website (see *Key Contacts*).

Paper Claims

The services described in this manual are billed on CMS-1500 claim forms. Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage
- Client has Medicaid, Medicare, and third party liability coverage
- Client has Medicaid, Medicare, and Medicare supplement coverage

When completing a claim, remember the following:

- Required fields are indicated by "*".
- Fields that are required if the information is applicable to the situation or client are indicated by "**".

Field 24h, *EPSDT/family planning*, is used to override cost sharing and PASSPORT authorization requirements for certain clients or services. The following are accepted codes:

EPSDT/Family Planning Overrides		
Code	**Client/Service**	**Purpose**
1	EPSDT	Overrides some benefit limits for client under age 21
2	Family planning	Overrides the Medicaid cost sharing and PASSPORT authorization on the line
3	EPSDT and family planning	Overrides Medicaid cost sharing and PASSPORT authorization for persons under the age of 21
4	Pregnancy (any service provided to a pregnant woman)	Overrides Medicaid cost sharing on the claim
6	Nursing facility client	Overrides the Medicare edit for oxygen services on the **line**

- Unless otherwise stated, all paper claims must be mailed to the following address:
  Claims Processing Unit
  P.O. Box 8000
  Helena, MT 59604

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibility, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

Client Has Medicaid Coverage Only

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a	Insured's ID number	Leave this field blank for Medicaid only claims.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
5	Patient's address	Client's address.
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11d*	Is there another health benefit plan?	Enter "No". If "Yes", follow claim instructions for appropriate coverage later in this chapter.
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format. This field is optional for Medicaid only claims.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format. This field is optional for Medicaid only claims.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization. This field is optional for Medicaid only claims.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B: Place of Service Codes*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter the appropriate CPT-4/HCPCS modifier. Medicaid allows up to three modifiers per procedure code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave blank or enter $0.00. Do not report any client copay or Medicaid payment amounts on this form.
30	Balance due	Enter the balance due as recorded in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which is either hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Rhoads, Rocky

3. PATIENT'S BIRTH DATE MM DD YY: 04 28 92 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street): 123 Anystreet #1

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street)

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]; Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 357.0
2. 349.9
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 9999999999

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 19 04	07 19 04	12	0	K0005		1,2	2,050 00	1				
2 07 19 04	07 19 04	12	0	K0040		1,2	105 00	2				
3 07 19 04	07 19 04	12	0	K0075		1,2	65 00	2				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [X]

26. PATIENT'S ACCOUNT NO.: 99999

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 2,220 00

29. AMOUNT PAID: $ 0 00

30. BALANCE DUE: $ 2,220 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Bender, 08/02/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Hometown Medical Equipment
P.O. Box 999
Anytown, MT 59999

PIN# 0000099999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Client Has Medicaid and Medicare Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	This field should be blank.
11c	Insurance plan or program	This field should be blank.
11d*	Is there another health benefit plan?	Check "NO".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B: Place of Service Codes*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29	Amount paid	Leave this field blank. Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30	Balance due	Enter the balance due as listed in field 28.
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Frost, Autumn

3. PATIENT'S BIRTH DATE: 02 04 28 SEX: M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 496.__ 3. _____.__

2. _____.__ 4. _____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 01 04	07 31 04	12	0	E1390	RR	1	325 00	1				
2 07 01 04	07 31 04	12	0	E0431	RR	1	50 00	1				
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 99-9999999

26. PATIENT'S ACCOUNT NO.: 99999999ABC

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 375 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 375 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Pullman 08/02/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Hometown Medical Equipment
P.O. Box 999
Anytown, MT 59999

PIN# 9999999 GRP# (406) 555-5555

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid and Third Party Liability Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's ID number for the primary carrier.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11	Insured's policy group	Leave this field blank, or enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B: Place of Service Codes*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the other insurance. Do not include any adjustment amounts or coinsurance.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Summer, Stormie

3. PATIENT'S BIRTH DATE MM DD YY: 08 31 59 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 4321 Anystreet

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 9999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [X] YES [ ] NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 490. 3. .

2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 02 04	07 02 04	12	0	E0570	RR	1	25 00	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE $ 25 00

29. AMOUNT PAID $ 20 00

30. BALANCE DUE $ 5 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Susan Pullman 08/02/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Hometown Medical Supply
P.O. Box 999
Anytown, MT 59999
(406) 999-9999

PIN# 999999 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Third Party Liability Coverage

Field#	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's primary payer (TPL) ID number.
11c*	Insurance plan or program	Enter the name of the primary payer.
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B: Place of Service Codes*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	Enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	If applicable, enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the primary payer (not Medicare). Do not include any adjustment amounts or coinsurance. The Medicare payment amount will be determined from the EOMB attached to the claim.
30*	Balance due	Enter the balance due (the amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Third Party Liability Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ( ) (Medicare #) | MEDICAID (X) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Knight, Tuesday

3. PATIENT'S BIRTH DATE: 11 07 22 SEX: M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 98765 Anystreet #2

6. PATIENT RELATIONSHIP TO INSURED: Self (X) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single (X) Married ( ) Other ( )

CITY: STATE:

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406)999-9999

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999A

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY SEX: M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX: M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? (X) YES ( ) NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO (X) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 496 . 3. . 2. . 4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 30 04	07 30 04	12	0	A7015		1,2	5 00	1				
2 07 01 04	07 31 04	12	0	E1390	RR	1,2	325 00	1				
3 07 01 04	07 31 04	12	0	E0431	RR	1,2	50 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 (X)

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) (X) YES ( ) NO

28. TOTAL CHARGE $ 380 00

29. AMOUNT PAID $ 304 00

30. BALANCE DUE $ 76 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Bender 08/02/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Hometown Medical Equipment
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

Field #	Field Title	Instructions
1	Program	Check Medicaid.
1a*	Insured's ID number	Enter the client's Medicare ID number.
2*	Patient's name	Enter the client's name as it appears on the Medicaid client's eligibility information.
3	Patient's birth date and sex	Client's birth date in month/day/year format. Check male or female box.
4	Insured's name	Enter the name of the insured or "SAME."
5	Patient's address	Client's address.
7	Insured's address	Enter the insured's address and telephone number or "SAME."
9 -9d	Other insured's information	Use these fields only if there are two or more third party insurance carriers (not including Medicaid and Medicare).
10	Is patient's condition related to:	Check "Yes" or "No" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in field 24. If you answered "yes" to any of these, enter the two-letter state abbreviation where the accident occurred on the "Place" line.
10d*	Reserved for local use	Enter the client's Medicaid ID number as it appears on the client's Medicaid eligibility information.
11*	Insured's policy group	Enter the client's ID number for the primary payer.
11c*	Insurance plan or program	Enter the name of the other insurance plan or program (i.e. BlueCross BlueShield, New West, etc.).
11d*	Is there another health benefit plan?	Check "YES".
14	Date of current illness, injury, pregnancy	Enter date in month/day/year format.
16	Dates patient unable to work in current occupation	If applicable, enter date in month/day/year format.
17	Name of referring physician	Enter the name of the referring physician. For PASSPORT clients, the name of the client's PASSPORT provider goes here.
17a	ID number of referring physician	Enter the referring or ordering physician's Medicaid ID number. For PASSPORT clients, enter the client's PASSPORT provider's PASSPORT ID number.
18	Hospitalization dates related to current service	Enter dates if the medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Reserved for local use	This field is used for any special messages regarding the claim or client.
20	Outside lab?	Check "No". Medicaid requires all lab tests to be billed directly by the provider who performed them.
21*	Diagnosis or nature of illness or injury	Enter the appropriate ICD-9-CM diagnosis codes. Enter up to four codes in priority order (primary, secondary, etc.).
23**	Prior authorization number	If the service requires prior authorization (PA), enter the PA number you received for this service.
24a*	Date(s) of service	Enter date(s) of service for each procedure, service, or supply.
24b*	Place of service	Enter the appropriate two-digit place of service (see *Appendix B: Place of Service Codes*).
24c*	Type of service	Enter Montana's type of service code: Nursing facilities are "9", and all others are "0" (zero).
24d*	Procedure, service, or supplies	If applicable, enter the appropriate CPT-4 or HCPCS code for the procedure, service, or supply. When applicable, enter appropriate modifiers. Medicaid recognizes two pricing and one informational modifier per code.
24e*	Diagnosis code	Enter the corresponding diagnosis code **reference number** (1, 2, 3 or 4) from field 21 (do not enter the diagnosis code). Any combination of applicable diagnosis reference numbers may be listed on one line.
24f*	Charges	Enter your reasonable and customary charges (or the Department-designated charges) for the procedure(s) on this line.
24g*	Days or units	Enter the number of units or days for the procedure and date(s) of service billed on this line (see *Billing Procedures, Coding* for additional tips on days/units). Anesthesia providers must bill using minutes.
24h**	EPSDT/family planning	Enter the appropriate code for the client/service: 1, 2, 3, 4, 5 or 6 (see complete description in the *EPSDT/Family Planning Overrides* table in this chapter).
24i**	EMG (Emergency)	Enter an "X" if this service was rendered in a hospital emergency room to override Medicaid copay.
28*	Total charge	Enter the sum of all charges billed in field 24f.
29*	Amount paid	Enter the amount paid by the Medicare supplement insurance only. Do not include any adjustment amounts or coinsurance. Medicare payment is determined from the EOMB attached to the claim.
30*	Balance due	Enter balance due (amount in field 28 less the amount in field 29).
31*	Signature and date	This field must contain an authorized signature and date, which can be hand signed, stamped, or computer generated.
32	Name and address of facility	Enter the name and address of the person, organization, or facility performing the services if other than the client's home or physician's office.
33*	Physician's, supplier's billing name, address, phone number	Enter the name, address, phone number and Montana Medicaid provider number (not UPIN) of the physician or supplier who furnished service.

* = Required Field ** = Required if applicable

Client Has Medicaid, Medicare, and Medicare Supplement Coverage

APPROVED OMB-0938-0008

For Medicaid use. Do not write in this area.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 999999999A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Summers, Stormie

3. PATIENT'S BIRTH DATE MM DD YY: 05 13 33 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Same

5. PATIENT'S ADDRESS (No., Street): 123 Sun City Road

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): Same

CITY: Anytown STATE: MT

8. PATIENT STATUS: Single [X] Married [ ] Other [ ]

CITY STATE

ZIP CODE: 59999 TELEPHONE (Include Area Code): (406) 555-5555

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 999999999B

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: Paywell Supplemental Insurance

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE: 999999999

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [X] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 496.__ 3. ____.__

2. ____.__ 4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 07 01 04	07 31 04	12	0	E1390	RR	1	325 00	1				
2 07 01 04	07 31 04	12	0	E0431	RR	1	50 00	1				
3 07 31 04	07 31 04	12	0	A7003		1	8 00	1				
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 99-9999999 [X]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 393 00

29. AMOUNT PAID: $ 314 40

30. BALANCE DUE: $ 78 60

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Bender 08/02/04

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Hometown Medical Equipment
P.O. Box 999
Anytown, MT 59999

PIN# 999999 GRP# (406) 999-9999

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

CMS-1500 Agreement

Your signature on the CMS-1500 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required field is blank	Check the claim instructions in this chapter for required fields (indicated by * or **). If a required field is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required field (field 10d); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility information.
Client name missing	This is a required field (field 2); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in field 23 (see *Prior Authorization and PASSPORT* in this manual).
Not enough information regarding other coverage	Fields 1a and 11d are required fields when a client has other coverage (refer to the examples in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, computer generated, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a CMS-1500 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the field. Information must not be obscured by lines.
Medicare EOMB not attached	When Medicare is involved in payment on a claim, the Medicare EOMB must be included with the claim or it will be denied.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

Electronic RAs are available for only six weeks on MEPS.

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* (see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

If a claim was denied, read the reason and remark code description before taking any action on the claim.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid and any claims paid with denied lines during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit requiring the provider to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/ Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)
HOMETOWN MEDICAL EQUIPMENT
P.O. BOX 999
ANYTOWN, MT 59999

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:08/15/04 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM (10)	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	070104	070104	1	K0005	2,050.00	1,640.00	Y	
(9) ICN	0041830050000700								
		LESS MEDICARE PAID*******							
		LESS COPAY DEDUCTION**					5.00 (17)		
		CLAIM TOTAL*******				2,050.00	1,635.00		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JANE	070104	070104	1	E0570	25.00	0.00	N	
ICN	0041830050000800						(17)	N	
		CLAIM TOTAL*******				25.00			31MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, SUSAN	070104	073104	1	E1390	325.00	0.00 (17)	N	133
ICN	0041830050000900	070104	073104	1	E0431	50.00	0.00	N	133
		CLAIM TOTAL*******				380.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

133 THE DISPOSITION OF THIS CLAIM/SERVICE IS PENDING FURTHER REVIEW.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day; the same date will appear in both columns
11. Unit of service	The number of services rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Co-pay	A "Y" indicates cost sharing was deducted, and an "N" indicates cost sharing was not deducted from the payment.
16. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, Billed Amount, and Paid Amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The Credit Balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

Rebilling Medicaid

Rebilling occurs when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. An adjustment form should be used for claims with denied lines that have codes that must be billed together (see *Adjustments*).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Submitting a Claim, Claim Inquiry*). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*), to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table, *Completing an Individual Adjustment Request Form*).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
    - Enter the date of service or the line number in the *Date of Service or Line Number* column.
    - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
    - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
    - If the original claim was billed electronically, a copy of the RA will suffice.
    - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS Name: Hometown Medical Equip. Street or P.O. Box: P.O. Box 999 City State Zip: Anytown, MT 59999	3. INTERNAL CONTROL NUMBER (ICN): 00404011250000600 4. PROVIDER NUMBER: 1234567 5. CLIENT ID NUMBER: 123456789 6. DATE OF PAYMENT: 10/01/04 7. AMOUNT OF PAYMENT $: 180.00
2. CLIENT NAME: Jane Doe	

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	09/01/04	09/15/04
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: Mary Bender **DATE:** 10/15/04

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

5. Send the adjustment request to Provider Relations (see *Key Contacts*).

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name is here.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field #5 (see the sample RA in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field #17 (see the sample RA in this chapter.).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ N.D.C/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key to the Paper RA* in this chapter).

Payment and The RA

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter in order to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Usual and Customary Charge (ARM 37.85.406, 37.86.1806)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to other payers for that service. The amount of the provider's usual and customary charge may not exceed the reasonable charge usually and customarily charged by the provider to all payers. For DMEPOS providers, a charge is considered reasonable if it is less than or equal to the manufacturer's suggested list price.

For items without a manufacture's suggested list price, the charge is considered reasonable if the provider's acquisition cost from the manufacturer is at least 50% of the charge amount. For items that are custom fabricated at the place of service, the amount charged will be considered reasonable if it does not exceed the average charge of all Medicaid providers by more than 20%.

Payment for DMEPOS Items/Services (ARM 37.86.1807)

Payment for DMEPOS is equal to the lowest of either the provider's usual and customary charge for the item or the Medicaid fee schedule amount in effect for the date of service.

Medicaid payment is equal to 100% of Medicare Region D fee schedule for current procedure codes where a Medicare fee is available, less applicable cost sharing, incurment and/or other applicable fees. Generic, miscellaneous, or wheelchair procedure codes are excluded from the Medicare fee schedule. Payment for such excluded procedure codes is 75% of the provider's submitted charge. For all other procedure codes where no Medicare fee is available, payment is 75% of the submitted charge until a reasonable fee is established through a pricing cluster.

A pricing cluster is obtained from a current commercial database containing several product retail price lists from different manufacturers/distributors. Such pricing is used to compare all provider charges for an item/service billed under a specific procedure code. The average charge from a 12-month period is considered reasonable if equal to or less than the average retail price of the pricing clus-

ter. Excluding wheelchair, generic and miscellaneous procedure codes, if the average charge is considered reasonable, a permanent fee is set at 75% of the reasonable charge.

Rental items

If the purchase of a rental item is cost effective in relation to the patient's need of the item, the purchase may be negotiated. The purchase price would be the amount indicated on the applicable fee schedule, less previous payments made to the provider of the item.

Total Medicaid rental reimbursement for items listed in Medicare's capped rental program or classified by Medicare as routine and inexpensive rental is limited to 120% of the purchase price for that item. Monthly rental fees are limited to 10% of the purchase for the item, limited to 12 monthly payments. Interruptions in the rental period of less than 60 days do not result in the start of a new 12-month period or new 120% of purchase price limit, but periods during which service is interrupted will not count toward the 12-month limit.

How Cost Sharing is Calculated on Medicaid Claims

Client cost sharing for services provided by DMEPOS providers is $5.00 per visit. The client's cost sharing amount is shown on the remittance advice and deducted from the Medicaid allowed amount (see the *Remittance Advices and Adjustments* chapter in this manual). For example, a DMEPOS provider supplies a Medicaid client with a set of crutches (E0114). The Medicaid allowed amount in July 2004 for this item is $8.57. The client owes the provider $5.00 for cost sharing, and Medicaid would pay the provider the remaining $3.57.

How Payment is Calculated on TPL Claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer (as described in the C*oordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. For example, a Medicaid client who also has insurance through her job receives a nebulizer (E0570) for her bronchitis. The client's other insurance is billed first and pays $10.00. The Medicaid allowed amount for this service is $19.73. The amount the other insurance paid ($10.00) is subtracted from the Medicaid allowed amount ($19.73), leaving a balance of $9.73. The Medicaid cost sharing ($5.00) is deducted from the balance, leaving a net payment of $4.73 on this claim.

How Payment is Calculated on Medicare Crossover Claims

When a client has coverage from both Medicaid and Medicare, Medicare is the primary payer as described in the *Coordination of Benefits* chapter of this manual. Medicaid then makes a payment as the secondary payer. For the provider types covered in this manual, Medicaid's payment is calculated so that the total payment to the provider is either the Medicaid allowed amount less the Medicare paid amount or the sum of the Medicare coinsurance and deductible, whichever is lower. This method is sometimes called "lower of" pricing. The following scenarios are examples of how a Medicare crossover claim is paid. Medicaid incurment is not considered in the following examples. These are only examples and may not reflect current rates.

Scenario 1: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has already met Medicare deductible.

A provider supplies a client who is eligible for both Medicare and Medicaid with a walker. The client has already met Medicare's requirement for a $100 deductible per year. The Medicare allowed amount for this service (E0149) is $22.32. As usual, the Medicare program pays the provider 80% of this amount, or $17.86. The client would be personally responsible for the balance (or coinsurance) of $4.46, except that he has Medicaid as secondary coverage.

Scenario 1

$ 22.32 Medicare allow.
x 80% Medicare rate
$ 17.86 Medicare paid

$ 22.32 Medicare allow.
- 17.86 Medicare paid
$ 4.46 Medicare coinsurance

$ 26.25 Medicaid allow.
- 17.86 Medicare paid
$ 8.39

$4.46 < $8.39
$4.46 Medicaid pays

Medicaid's allowed amount for this service is $26.25. Because Medicare already paid $17.86, that would leave a difference of $8.39. Medicaid then compares the coinsurance amount ($4.46) to the Medicaid balance ($8.39) and pays the lower of the two amounts. The provider will receive $4.46 from Medicaid for this claim.

Scenario 2: Dually eligible client, Medicare paid amount is lower than Medicaid allowed amount, client has not met Medicare deductible, client has met Medicaid cost sharing cap.

This scenario is the same as Scenario 1, except that the client has not yet met his $100 Medicare deductible. The Medicare allowed amount is $22.32, but because that amount is applied to the client's deductible, Medicare pays zero. The Medicaid allowed amount is $26.25. Medicaid will pay the lower of $22.32 and $26.25. Medicaid will pay the provider $22.32 for this claim.

Scenario 2

$ 22.32 Medicare allowed
- 22.32 Applied to deductible
$ 0.00 Medicare paid

$ 26.25 Medicaid allowed
- 0.00 Medicare paid
$ 26.25

$22.32 < $26.25
$22.32 Medicaid pays

Appendix A: Forms

- ***Montana Medicaid /MHSP/CHIP Individual Adjustment Request***
- ***Montana Medicaid Claim Inquiry Form***
- ***Paperwork Attachment Cover Sheet***
- ***Certificates of Medical Necessity***
  - *Enteral Nutrition (CMS-853)*
  - *External Infusion Pump (CMS-851)*
  - *Hospital Bed (CMS-841)*
  - *Lymphedema Pumps (Pneumatic Compression Devices) (CMS-846)*
  - *Manual Wheelchairs (CMS-844)*
  - *Motorized Wheelchairs (CMS-843)*
  - *Osteogenesis Stimulators (CMS-847)*
  - *Oxygen (CMS-484)*
  - *Parenteral Nutrition (CMS-852)*
  - *Power Operated Vehicles (POV) (CMS-850)*
  - *Seat Lift Mechanisms (CMS-849)*
  - *Section C Continuation Form (CMS-854)*
  - *Support Surfaces (CMS-842)*
  - *Transcutaneous Electrical Nerve Stimulators (TENS) (CMS-848)*
- ***DMEPOS Medical Review Request Form***
- ***Request for Blanket Denial Letter***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
	_____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 10.02B

ENTERAL NUTRITION

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____ _____
	PT DOB ____/____/____; Sex ____ (M/F) ; HT._____(in.) ; WT._____(lbs.) **PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __**

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)	**DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 7, 8, AND 10 - 15 FOR ENTERAL NUTRITION (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Questions 1 - 6, and 9, reserved for other or future use.
Y N	7. Does the patient have permanent non-function or disease of the structures that normally permit food to reach or be absorbed from the small bowel?
Y N	8. Does the patient require tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status?
A) _____ B) _____	10. Print product name(s).
A) _____ B) _____	11. Calories per day for each product?
_____	12. Days per week administered? (Enter 1 - 7)
1 2 3 4	13. Circle the number for method of administration? 1 - Syringe 2 - Gravity 3 - Pump 4 - Does not apply
Y N D	14. Does the patient have a documented allergy or intolerance to semi-synthetic nutrients?
	15. Additional information when required by policy:

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____ /____ /_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 09.02

EXTERNAL INFUSION PUMP

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODES:	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See reverse)	_____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)**
	_____	
	_____	**PHYSICIAN'S UPIN:** _____
	_____	**PHYSICIAN'S TELEPHONE #:** (__ __ __) __ __ __- __ __ __ __

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED IN AGGREGATE (# OF MONTHS): _____**1-99 (99=LIFETIME)**	**DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1 - 7 FOR EXTERNAL INFUSION PUMP. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
1 3 4	1. Circle number of pump which has been prescribed: 1 - External infusion pump (non-disposable); 2 - Reserved for other or future use; 3 - Implantable infusion pump; 4 - Disposable infusion pump (e.g., elastomeric)
HCPCS CODE: _____	2. Provide the HCPCS code for the drug that requires the use of the pump.
_____	3. If non-specific code was used to answer questions, print name of drug.
1 3 4	4. Circle number for route of administration? 1 - Intravenous; 2 - Reserved for other or future use; 3 - Epidural; 4 - Subcutaneous
1 2 3	5. Circle number for method of administration? 1 - Continuous; 2 - Intermittent; 3 - Bolus
_____	6. What is the total duration of drug infusion per 24 hours? (1 - 24)
Y N D	7. Does the patient have intractable cancer pain which has failed to respond to an adequate oral/transdermal narcotic analgesic regimen or is the patient unable to tolerate oral/transdermal narcotics?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ___ / ___ / ____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 01.02A

HOSPITAL BEDS

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See reverse	HCPCS CODE	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
	_____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)**
	_____	
	_____	**PHYSICIAN'S UPIN:** _____
	_____	**PHYSICIAN'S TELEPHONE #:** (__ __ __) __ __ __- __ __ __ __

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1, AND 3-7 FOR HOSPITAL BEDS (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	QUESTION 2 RESERVED FOR OTHER OR FUTURE USE.
Y N D	1. Does the patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?
Y N D	3. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed?
Y N D	4. Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or aspiration?
Y N D	5. Does the patient require traction which can only be attached to a hospital bed?
Y N D	6. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position?
Y N D	7. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 04.03B

LYMPHEDEMA PUMPS

SECTION A — Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____ _____	**PT DOB ____/____/____; Sex ____ (M/F) ; HT._____(in.) ; WT._____(lbs.)** PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B — Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1-5 FOR LYMPHEDEMA PUMP (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
Y N D	1. Does the patient have a malignant tumor with obstruction of the lymphatic drainage of an extremity?
Y N D	2. Has the patient had radical cancer surgery or radiation for cancer that interrupted normal lymphatic drainage of the extremity?
Y N D	3. Does the patient have chronic venous insufficiency with venous stasis ulcer(s)? (If YES, additional documentation must accompany the claim.)
Y N D	4. Is there a congenital abnormality of lymphatic drainage? (If YES, additional documentation must accompany the claim.)
Y N D	5. Are you the treating physician and have you prescribed the pressures to be used and the frequency and duration of use of this device?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C — Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D — Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03B

MANUAL WHEELCHAIRS

SECTION A — Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ HCPCS CODES:	**PT DOB ____/____/____; Sex ____ (M/F); HT._____(in.); WT._____(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER
_____	(__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B — Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Manual Whlchr Base And All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Ht. Armrest; Any Type Ltwt. Whlchr	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Any Type Ltwt. Whlchr	Y N D	8. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Ltwt. Whlchr	Y N D	9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C — Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on CMS 854.

❒ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON CMS 854**

SECTION D — Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARE SERVICES

FORM APPROVED
OMB NO. 0938-0875

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03A

MOTORIZED WHEELCHAIRS

SECTION A — Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____ _____
PT DOB ___/___/___; Sex ___ (M/F); HT.____(in.); WT.____(lbs.) PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __)__ __ __-__ __ __ __ UPIN # _____	

SECTION B — Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME) | **DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 6 AND 7 FOR MOTORIZED WHEELCHAIR BASE, 1-5 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
Motorized Whlchr Base and All Accessories	Y N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y N D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y N D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y N D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Height Armrest	_____	5. How many hours per day does the patient usually spend in the wheelchair? (1–24) (Round up to the next hour)
Motorized Whlchr Base	Y N D	6. Does the patient have severe weakness of the upper extremities due to a neurologic, muscular, or cardiopulmonary disease/condition?
Motorized Whlchr Base	Y N D	7. Is the patient unable to operate any type of manual wheelchair?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C — Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on Form CMS-854.

❒ **CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON Form CMS-854**

SECTION D — Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 04.03C

OSTEOGENESIS STIMULATORS

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ NAME and ADDRESS of FACILITY if applicable (See Reverse)	HCPCS CODES: _____ _____ _____ _____
PT DOB ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)** PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER (__ __ __)__ __ __-__ __ __ __ UPIN#_____	

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 6-8 FOR NONSPINAL OSTEOGENESIS STIMULATOR. ANSWER QUESTIONS 9-11 FOR SPINAL OSTEOGENESIS STIMULATOR. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply. For questions about months, enter 1–99 or D. If less than one month, enter 1.)
a) Y N D b) _____	6. (a) Does the patient have a nonunion of a long-bone fracture? (b) How many months prior to ordering the device did the patient sustain the fracture?
a) Y N D b) _____	7. (a) Does the patient have a failed fusion of a joint other than the spine? (b) How many months prior to ordering the device did the patient have the fusion?
Y N D	8. Does the patient have a congenital pseudoarthrosis?
a) Y N D b) _____	9. (a) Is the device being ordered as a treatment of a failed spinal fusion in a patient who has not had a recent repeat fusion? (b) How many months prior to ordering the device did the patient have the fusion?
a) Y N D b) _____ c) _____	10. (a) Is the device being ordered as an adjunct to repeat spinal fusion surgery in a patient with a previously failed spinal fusion at the same level(s)? (b) How many months prior to ordering the device did the patient have the repeat fusion? (c) How many months prior to ordering the device did the patient have the previously failed fusion?
a) Y N D b) _____	11. (a) Is the device being ordered as an adjunct to recent spinal fusion surgery in a patient who has had a multi-level fusion? (b) How many months prior to ordering the device did the patient have the multi-level fusion?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0534

CERTIFICATE OF MEDICAL NECESSITY

DMERC 484.2

OXYGEN

SECTION A Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION __/___/__

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ HCPCS CODE	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER
	(__ __ __) __ __ __ - __ __ __ __ UPIN # _____

SECTION B Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1-10. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, unless otherwise noted.)
a) _____ mm Hg b) _____% c) ___/___/___	1. Enter the result of most recent test taken on or before the certification date listed in Section A. Enter (a) arterial blood gas PO_2 and/or (b) oxygen saturation test. Enter date of test (c).
Y N	2. Was the test in Question 1 performed **EITHER** with the patient in a chronic stable state as an outpatient **OR** within two days prior to discharge from an inpatient facility to home?
1 2 3	3. Circle the one number for the condition of the test in Question 1: (1) At Rest; (2) During Exercise; (3) During Sleep
XXXXXXXXXXXXXX XXXXXXXXXXXXXX XXXXXXXXXXXXXX	4. Physician/provider performing test in Question 1 (and, if applicable, Question 7). Print/type name and address below: NAME: ADDRESS:
Y N D	5. If you are ordering portable oxygen, is the patient mobile within the home? If you are not ordering portable oxygen, circle D.
_____ LPM	6. Enter the highest oxygen flow rate ordered for this patient in liters per minute. If less than 1 LPM, enter a "**X**".
a) _____ mm Hg b) _____% c) ___/___/___	7. If greater than 4 LPM is prescribed, enter results of most recent test taken on 4 LPM. This may be an (a) arterial blood gas PO_2 and/or (b) oxygen saturation test with patient in a chronic stable state. Enter date of test (c).
IF PO_2 = 56–59 OR OXYGEN SATURATION = 89%, AT LEAST ONE OF THE FOLLOWING CRITERIA MUST BE MET.	
Y N D	8. Does the patient have dependent edema due to congestive heart failure?
Y N D	9. Does the patient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an EKG or by an echocardiogram, gated blood pool scan or direct pulmonary artery pressure measurement?
Y N D	10. Does the patient have a hematocrit greater than 56%?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C Narrative Description of Equipment and Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. (See instructions on back.)

SECTION D Physician Attestation and Signature/Date

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the treating physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the treating physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 10.02A

PARENTERAL NUTRITION

SECTION A **Certification Type/Date: INITIAL ___/___/___ REVISED ___/___/___ RECERTIFICATION ___/___/___**

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODES:	**PT DOB ____/____/____; Sex ____ (M/F) ; HT._____(in.) ; WT._____(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN: _____** **PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __**

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)	**DIAGNOSIS CODES (ICD-9): _____ _____ _____ _____**

ANSWERS	ANSWER QUESTIONS 1, AND 3 - 5 FOR PARENTERAL NUTRITION (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	Question 2 reserved for other or future use.
Y N	1. Does the patient have severe permanent disease of the gastrointestinal tract causing malabsorption severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status?
_____	3. Days per week infused? (Enter 1 - 7).
	4. Formula components: Amino Acid _____ (ml/day)_____ concentration % _____gms protein/day Dextrose _____(ml/day) _____ concentration % Lipids _____(ml/day) _____days/week _____ concentration %
1 3 7	5. Circle the number for the route of administration. 2, 4, 5, 6 - Reserved for other or future use. 1 - Central Line; 3 - Hemodialysis Access Line; 7 - Peripherally Inserted Catheter (PIC)

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e.; patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 07.02B

POWER OPERATED VEHICLE (POV)

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ HCPCS CODES:	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse) _____ _____ _____ _____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #: (**__ __ __**)** __ __ __**-** __ __ __ __

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 6 - 14 FOR POWER OPERATED VEHICLE (POV) (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
	Questions 1 - 5, and 9 - 11, reserved for other or future use.
Y N D	6. Does the patient require a POV to move around in their residence?
Y N D	7. Have all types of manual wheelchairs (including lightweights) been considered and ruled out?
Y N D	8. Does the patient require a POV only for movement outside their residence?
Y N D	12. Is the physician signing this form a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	13. Is the patient more than one day's round trip from a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?
Y N D	14. Does the patient's physical condition prevent a visit to a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 07.02A

SEAT LIFT MECHANISM

SECTION A **Certification Type/Date:** **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODE:	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __**

SECTION B **Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** | **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1 -5 FOR SEAT LIFT MECHANISM (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply)
Y N D	1. Does the patient have severe arthritis of the hip or knee?
Y N D	2. Does the patient have a severe neuromuscular disease?
Y N D	3. Is the patient completely incapable of standing up from a regular armchair or <u>any</u> chair in his/her home?
Y N D	4. Once standing, does the patient have the ability to ambulate?
Y N D	5. Have all appropriate therapeutic modalities to enable the patient to transfer from a chair to a standing position (e.g., medication, physical therapy) been tried and failed? If YES, this is documented in the patient's medical records.

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C **Narrative Description Of Equipment And Cost**

(1) <u>Narrative</u> description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for <u>each</u> item, accessory, and option. *(See Instructions On Back)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____ /_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 11.01

SECTION C CONTINUATION FORM

PATIENT'S NAME _____ HICN _____

SECTION C *(continued)* **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge and **(3)** Medicare Fee Schedule Allowance for each item, accessory and option. *(See instructions on back.)*

SECTION D **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of the attached form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

CMS 854 (5/97)

SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 01.02B

SUPPORT SURFACES

SECTION A

Certification Type/Date: **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____
PLACE OF SERVICE _____ HCPCS CODE:	**PT DOB** ____/____/____; **Sex**_____**(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	**PHYSICIAN NAME, ADDRESS (Printed or Typed)**
	PHYSICIAN'S UPIN: _____
	PHYSICIAN'S TELEPHONE #: (__ __ __) __ __ __- __ __ __ __

SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 12, 13 & 21 (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
	QUESTIONS 1-11, 17 AND 18 ARE RESERVED FOR OTHER OR FUTURE USE.
Y N D	12. Is the patient highly susceptible to decubitus ulcers?
Y N D	13. Are you supervising the use of the device?
Y N D	14. Does the patient have coexisting pulmonary disease?
Y N D	15. Has a conservative treatment program been tried without success?
Y N D	16. Was a comprehensive assessment performed after failure of conservative treatment?
Y N D	19. Are open, moist dressings used for the treatment of the patient?
Y N D	20. Is there a trained full-time caregiver to assist the patient and manage all aspects involved with the use of the bed?
	21. Provide the stage and size of each pressure ulcer necessitating the use of the overlay, mattress or bed. If the patient is highly susceptible to decubitus ulcers, but currently has no ulcer present, place a "9" under ulcer #1.
	Pressure Ulcer / Ulcer # 1 / Ulcer # 2 / Ulcer # 3
	Stage: _____ _____ _____
	Max. Length (cm): _____ _____ _____
	Max. Width (cm): _____ _____ _____
1 2 3	22. Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE _____/_____/_____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED or RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories, supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies (1) the CMN which he/she is reviewing includes Sections A, B, C and D; (2) the answers in Section B are correct; and (3) the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE AND DATE:	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 06.02B

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS)

SECTION A

Certification Type/Date: **INITIAL** ___/___/___ **REVISED** ___/___/___

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER	SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
(__ __ __) __ __ __ - __ __ __ __ HICN _____	(__ __ __) __ __ __ - __ __ __ __ NSC # _____

PLACE OF SERVICE _____	HCPCS CODE:	**PT DOB** ____/____/____; **Sex** ____ **(M/F)** ; **HT.**_____**(in.)** ; **WT.**_____**(lbs.)**
NAME and ADDRESS of FACILITY if applicable (See Reverse)	_____ _____ _____ _____	**PHYSICIAN NAME, ADDRESS (Printed or Typed)** **PHYSICIAN'S UPIN:** _____ **PHYSICIAN'S TELEPHONE #:** (__ __ __) __ __ __- __ __ __ __

SECTION B

Information in this Section May Not Be Completed by the Supplier of the Items/Supplies.

EST. LENGTH OF NEED (# OF MONTHS): _____ **1-99 (99=LIFETIME)** **DIAGNOSIS CODES (ICD-9):** _____ _____ _____ _____

ANSWERS	ANSWER QUESTIONS 1 - 6 FOR RENTAL OF TENS, AND 3 - 12 FOR PURCHASE OF TENS. (Circle **Y** for Yes, **N** for No, or **D** for Does Not Apply, Unless Otherwise Noted)
Y N D	1. Does the patient have acute post-operative pain?
___/___/____	2. What is the date of surgery resulting in acute post-operative pain?
Y N D	3. Does the patient have chronic, intractable pain?
[_____ months]	4. How long has the patient had intractable pain? (Enter number of months, 1 - 99.)
1 2 3 4 5	5. Is the TENS unit being prescribed for any of the following conditions? (Circle appropriate number) 1 - Headache 2 - Visceral abdominal pain 3 - Pelvic pain 4 - Temporomandibular joint (TMJ) pain 5 - None of the above
Y N D	6. Is there documentation in the medical record of multiple medications and/or other therapies that have been tried and failed?
Y N D	7. Has the patient received a TENS trial?
Began/Ended ___/___/___ ___/___/___	8. What are the dates that trial of TENS unit began and ended?
___/___/___	9. What is the date that you reevaluated the patient at the end of the trial period?
1 2 3	10. How often has the patient been using the TENS? (Circle appropriate number) 1 = Daily 2 = 3 to 6 days per week 3 = 2 or less days per week
Y N D	11. Do you and the patient agree that there has been a significant improvement in the pain and that long term use of a TENS is warranted?
2 4	12. Number of TENS leads (i.e., separate electrodes) routinely needed and used by the patient at any one time: (Circle appropriate number) 2 = 2 leads 4 = 4 leads

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: _____ TITLE: _____ EMPLOYER: _____

SECTION C

Narrative Description Of Equipment And Cost

(1) Narrative description of all items, accessories and options ordered; **(2)** Supplier's charge; and **(3)** Medicare Fee Schedule Allowance for each item, accessory, and option. *(See Instructions On Back)*

SECTION D

Physician Attestation and Signature/Date

I certify that I am the physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____ / ____ / ____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

SECTION A:	**(May be completed by the supplier)**
CERTIFICATION TYPE/DATE:	If this is an initial certification for this patient, indicate this by placing date (MM/DD/YY) needed initially in the space marked "INITIAL." If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "REVISED." If this is a recertification, indicate the initial date needed in the space marked "INITIAL," and also indicate the recertification date in the space marked "RECERTIFICATION." Whether submitting a REVISED or a RECERTIFIED CMN, be sure to always furnish the INITIAL date as well as the REVISED **or** RECERTIFICATION date.
PATIENT INFORMATION:	Indicate the patient's name, permanent legal address, telephone number and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
SUPPLIER INFORMATION:	Indicate the name of your company (supplier name), address and telephone number along with the Medicare Supplier Number assigned to you by the National Supplier Clearinghouse (NSC).
PLACE OF SERVICE:	Indicate the place in which the item is being used; i.e., patient's home is 12, skilled nursing facility (SNF) is 31, End Stage Renal Disease (ESRD) facility is 65, etc. Refer to the DMERC supplier manual for a complete list.
FACILITY NAME:	If the place of service is a facility, indicate the name and complete address of the facility.
HCPCS CODES:	List all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification should not be listed on the CMN.
PATIENT DOB, HEIGHT, WEIGHT AND SEX:	Indicate patient's date of birth (MM/DD/YY) and sex (male or female); height in inches and weight in pounds, if requested.
PHYSICIAN NAME, ADDRESS:	Indicate the physician's name and complete mailing address.
UPIN:	Accurately indicate the ordering physician's Unique Physician Identification Number (UPIN).
PHYSICIAN'S TELEPHONE NO:	Indicate the telephone number where the physician can be contacted (preferably where records would be accessible pertaining to this patient) if more information is needed.
SECTION B:	**(May not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed, and the CMN signed (in Section D) by the ordering physician.)**
EST. LENGTH OF NEED:	Indicate the estimated length of need (the length of time the physician expects the patient to require use of the ordered item) by filling in the appropriate number of months. If the physician expects that the patient will require the item for the duration of his/her life, then enter 99.
DIAGNOSIS CODES:	In the first space, list the ICD9 code that represents the primary reason for ordering this item. List any additional ICD9 codes that would further describe the medical need for the item (up to 3 codes).
QUESTION SECTION:	This section is used to gather clinical information to determine medical necessity. Answer each question which applies to the items ordered, circling "Y" for yes, "N" for no, "D" for does not apply, a number if this is offered as an answer option, or fill in the blank if other information is requested.
NAME OF PERSON ANSWERING SECTION B QUESTIONS:	If a clinical professional other than the ordering physician (e.g., home health nurse, physical therapist, dietician), or a physician employee answers the questions of Section B, he/she must print his/her name, give his/her professional title and the name of his/her employer where indicated. If the physician is answering the questions, this space may be left blank.
SECTION C:	**(To be completed by the supplier)**
NARRATIVE DESCRIPTION OF EQUIPMENT & COST:	Supplier gives **(1)** a narrative description of the item(s) ordered, as well as all options, accessories,supplies and drugs; **(2)** the supplier's charge for each item, option, accessory, supply and drug; and **(3)** the Medicare fee schedule allowance for each item/option/accessory/supply/drug, if applicable.
SECTION D:	**(To be completed by the physician)**
PHYSICIAN ATTESTATION:	The physician's signature certifies **(1)** the CMN which he/she is reviewing includes Sections A, B, C and D; **(2)** the answers in Section B are correct; and **(3)** the self-identifying information in Section A is correct.
PHYSICIAN SIGNATURE	After completion and/or review by the physician of Sections A, B and C, the physician must sign and date the CMN in Section D, verifying the Attestation appearing in this Section. The physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND MEDICAL SUPPLIES - (DMEPOS)

DMEPOS Medical Review Request Form

NOTE: Minimum-supporting documentation includes a prescription, Certificate of Medical Need (if required of the item) or a narrative summary detailing the need for the item from the prescribing authority, a manufacturers retail price sheet and product warranty information. If a licensed therapist is treating the patient, a copy of the patient's plan of care in relation to the item/service is also required. FAILURE TO PROVIDE THE MINIMUM REQUIREED DOCUMENTATION WILL RESULT IN THE RETURN OF THE INCOMPLETE REQUEST TO THE SUBMITTING DMEPOS PROVIDER.

ONLY ENROLLED DMEPOS PROVIDERS MAY SUBMIT REQUESTS

PATIENT NAME, DATE OF BIRTH, ADDRESS, TELEPHONE NUMBER:	**DMEPOS PROVIDER NAME, ADDRESS, TELEPHONE/FAX NUMBER:**
MEDICAID NUMBER:	**MEDICAID PROVIDER NUMBER:**

PLACE OF RESIDENCE: **PRIVATE HOME - GROUP HOME - NURSING HOME - INSTITUTION**

SPECIFICATION LIST

NOTE: ALL BILLABLE ITEMS THAT MAKE UP THIS REQUEST MUST BE LISTED INDIVIDUALLY BELOW. ANY ITEM THAT IS NOT LISTED BELOW IS SUBJECT TO RECOVERY IF ADDED AND BILLED TO MEDICAID AT A LATER TIME.

HCPCS	ITEM	MANUFACTURER	MODEL #	UNITS/ MONTHS	CHARGE

THE UNDERSIGNED CERTIFIES, THROUGH HIS/HER SIGNATURE, THAT HE/SHE HAS READ AND UNDERSTANDS THE CONDITIONS OF PARTICIPATION IN THE MONTANA MEDICAID PROGRAM [ARM 37.85.401], AND THAT THE INFORMATION PROVIDED BY HIS/HER HAND IS, TO THE BEST OF HIS/HER KNOWLEDGE, TRUE, ACCURATE AND COMPLETE.

SIGNATURE: _____ **DATE:** _____

REQUEST FOR BLANKET DENIAL LETTER

DATE REQUESTED_____ PROVIDER #_____

RECIPIENT NAME_____

MEDICAID ID #_____

INSURANCE COMPANY NAME ON FILE_____

PROCEDURE CODES NEEDED:

1._____

2._____

3._____

4._____

5._____

CONTACT_____

PHONE NUMBER_____

FAX NUMBER_____

PLEASE FAX ALL REQUESTS TO 406-442-0357

Appendix B: Place of Service Codes

Place of Service Codes

Codes	Names	Descriptions
01 - 02	Unassigned	N/A
03	School	A facility whose primary purpose is education.
04	Homeless shelter	A facility or location whose primary purpose is to provide temporary housing to homeless individuals (e.g., emergency shelters, individual or family shelters).
05	Indian Health Service Free-standing facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to American Indians and Alaska Natives who do not require hospitalization.
06	Indian Health Service Provider-based facility	A facility or location, owned and operated by the Indian Health Service, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services rendered by, or under the supervision of, physicians to American Indians and Alaska Natives admitted as inpatients or outpatients.
07	Tribal 638 Free-standing facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members who do not require hospitalization.
08	Tribal 638 Provider-based facility	A facility or location owned and operated by a federally recognized American Indian or Alaska Native tribe or tribal organization under a 638 agreement, which provides diagnostic, therapeutic (surgical and non-surgical), and rehabilitation services to tribal members admitted as inpatients or outpatients.
09 - 10	Unassigned	N/A
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13 - 14	Unassigned	N/A
15	Mobile unit	A facility/unit that moves from place-to-place equipped to provide preventive, screening, diagnostic, and/or treatment services.
16 - 19	Unassigned	N/A
20	Urgent care facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.

Place of Service Codes (continued)

Codes	Names	Descriptions
22	Outpatient hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency room - hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory surgical center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of newborn infants.
26	Military treatment facility	A medical facility operated by one or more of the uniformed services. Military treatment facility (MTF) also refers to certain former U.S. public health service (USPHS) facilities now designated as uniformed service treatment facilities (USTF).
27 - 30	Unassigned	N/A
31	Skilled nursing facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick person, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial care facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
35 - 40	Unassigned	N/A
41	Ambulance - land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance - air or water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
43 - 49	Unassigned	N/A
50	Federally qualified health center	A facility located in a medically underserved area that provides Medicare beneficiaries preventive primary medical care under the general direction of a physician.
51	Inpatient psychiatric facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
52	Psychiatric facility -partial hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.

Place of Service Codes (continued)

Codes	Names	Descriptions
53	Community mental health center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services: screening for patients being considered for admission to state mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate care facility/ mentally retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential substance abuse treatment facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric residential treatment center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57 - 59	Unassigned	N/A
60	Mass immunization center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive inpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy , occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive outpatient rehabilitation facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
63 - 64	Unassigned	N/A
65	End-stage renal disease treatment facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
66 - 70	Unassigned	N/A
71	State or local public health clinic	A facility maintained by either state or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural health clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
73 - 80	Unassigned	N/A
81	Independent laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
82 - 98	Unassigned	N/A
99	Other place of service	Other place of service not identified above.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Accessory
A medically necessary device or supply which augments or compliments the functions of the equipment to which it is connected.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

By Report
For services, supplies, or equipment that do not have a maximum allowance established, Montana Medicaid reimburses the provider based on a percentage of the provider's usual and customary charge for the allowed item or service. These items are identified in the Department's fee schedule.

Capped Rental
Rentals classified by Montana Medicaid and Medicare as capped rental items are limited to a 12-month rental period. Total monthly rental reimbursement is not to exceed 120% of the item's purchase price. All necessary supplies needed to operate the rented equipment item are included in the rental amount. No additional allowances are made.

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Certificate of Medical Need (CMN)
A CMN form contains all the information needed for the Department to determine if an item is medically necessary for the Medicaid client.

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicaid or Medicare (usually a percentage). Medicaid coinsurance is usually 5% of the Medicaid allowed amount, and Medicare coinsurance is usually 20% of the Medicare allowed amount.

Conversion Factor
A state specific dollar amount that converts relative values into an actual fee. This calculation allows each payer to adopt the RBRVS to its own economy.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Frequently Maintained Rental
Rentals that need frequent and substantial servicing are not subject to a cap and the provider may continue to rent the item as long as it is medically necessary. All supplies needed to operate the equipment are included in the rental fee.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Maximum Allowable
The maximum dollar amount for which a provider may be reimbursed as established by Montana Medicaid for specific services, supplies and/or equipment.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Relative Value Scale (RVS)
A numerical scale designed to permit comparisons of appropriate prices for various services. The RVS is made up of the relative value units (RVUs) for all the objects in the class for which it is developed.

Relative Value Unit
The numerical value given to each service in a relative value scale.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Resource-Based Relative Value Scale (RBRVS)
A method of determining physicians' fees based on the time, training, skill, and other factors required to deliver various services.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Special Health Services (SHS)
SHS assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)

This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

WINASAP 2003

WINASAP 2003 is a Windows-based electronic claims entry application for Montana Medicaid. This software was developed as an alternative to submitting claims on paper. For more information contact ACE EDI Gateway (see *Key Contacts*).

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